STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. Survey Dates: August 22, 23, 24 and 25, 2011 Facility Number: 009569 Provider Number: 155628 Aim Number: 200139920 Survey Team: Diana Zgonc, RN TC Connie Landman, RN Christi Davidson, RN Courtney Hamilton, RN Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 9 Medicaid: 76 Other: 7 Total: 92 Stage 2 Sample 33 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 30,	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2011 by Bev Faulkner, RN			
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review, observation, and interview, the facility failed to report 3 bruises (injury of unknown	F0225	1. The bruise on Resident #76 has resolved. 2. All residents have the potential to be affected.3. A facility wide	09/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	origin) in a timely manner for 1 of 1 resident with bruising (Resident # 76). Findings include: During an interview on 8/22/11 at 2:00 P.M., with Resident # 76, she indicated she had 3 bruises on her arm and could not remember how she got them. The bruising was observed to the resident's right forearm and was purple and black in color. The resident reported the information to the nurse at that time. The record for Resident # 76 was reviewed on 8/24/11 at 3:30 P.M. Diagnoses for Resident # 76 included but were not limited to Cerebrovascular Disease, Hypertension, Dementia, Esophageal Reflux, Depressive Disorder and Aphasia (due to Cerebrovascular Disease. During review of the Incident Report provided and reviewed on 8/25/11 at 11:00 A.M., the record lacked documentation of the incident being reported within 24 hours according to the facility policy. The Incident Report was dated 8/23/11, but the fax confirmation document was dated 8/24/11 at 16:07 (4:07 P.M.).		in-service was held to review the entire incident reporting process. The in-service included the requirement that all facility employees are responsible to immediately notify their immediate supervisor and the written notification will include the time and date of the incident as well as the reporting date/time. The direct supervisor is responsible to immediately notify the Administrator of the incident.4. A monthly audit will be conducted by the Administrator/designee of all incidents and a report will be prepared for the QA Committee.5. Correction date: 9/24/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with the Administrator on 8/25/11 at 10:50 A.M., she indicated we were in the process of doing an investigation and not sure if it needed to be reported so we missed the 24 hour time frame that it should have been reported. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review, observation, and interview, the facility failed to report 3 bruises (injury of unknown origin) in a timely manner according to their current facility policy for 1 of 1 resident with bruising (Resident # 76). Findings include: The record for Resident # 76 was reviewed on 8/24/11 at 3:30 P.M. Diagnoses for Resident # 76 included but were not limited to Cerebrovascular Disease, Hypertension, Dementia, Esophageal Reflux, Depressive Disorder and Aphasia due to Cerebrovascular Disease. During an interview on 8/22/11 at 2:00	F0226	1. The bruise on Resident #76 has resolved. 2. All residents have the potential to be affected. 3. A facility wide in-service was held to review the entire incident reporting process. The in-service included the requirement that all facility employees are responsible to immediately notify their immediate supervisor and the written notification will include the time and date of the incident as well as the reporting date/time. The direct supervisor is responsible to immediately notify the Administrator of the incident.4. A monthly audit will be conducted by the Administrator/designee of all incidents and a report will be prepared for the QA Committee.5. Correction Date: 9/24/2011	09/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	P.M., with Resident # 76, she indicated she had 3 bruises on her arm and could not remember how she got them. The bruising was observed to the resident's right forearm and was purple and black in color. The resident reported the information to the nurse at that time. During review of the Incident Report provided and reviewed on 8/25/11 at 11:00 A.M., the record lacked documentation of the incident being reported within 24 hours according to the facility policy. The Incident Report was dated 8/23/11, but the fax confirmation document was dated 8/24/11 at 16:07 (4:07 P.M.). During an interview with the Administrator on 8/25/11 at 10:50 A.M., she indicated we were in the process of doing an investigation and not sure if it needed to be reported so we missed the 24 hour time frame that it should have been reported. A current, undated, facility policy titled "Reportable Unusual Occurrences" and provided by the Administrator on 8/25/11 at 11:00 A.M., indicated, "Procedure: Occurrences to be reported Facilities are required by law to report unusual occurrences within 24 hours			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of occurrence to the Long Term Care Division ... the facility must ensure that all alleged violations ... including injuries of unknown source ... are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures ... (5) Injuries of Unknown Source An injury should be classified as an injury of unknown source when both of the following conditions are met: (A) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (B) the injury is suspicious because of the extent of the injury or the location of the injury ... or the number of injuries observed at one particular point in time or the incidence of injuries over time." 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop and implement a care plan for a resident transfer from the bed to the wheelchair based on an assessment for a transfer with a two person physical assist for 1 resident in a stage two sample of 33 residents reviewed for care plans. (Resident #19) Findings include: The record for Resident #19 was reviewed on 08/24/11 at 2:44 p.m. Diagnoses included, but were not limited to lower gastrointestinal bleed,	F0279	1. The care plans for Resident #19 were reviewed and updated as needed.2. All residents have the potential to be affected. The transfer needs of all residents will have care plans reviewed and updated as needed.3. All nurses will be in-serviced on initiating and completing care plans that reflect the transfer needs of the residents.4. The DON or designee will review 5 resident care plans monthly times three months, then quarterly thereafter to determine if resident's care plans reflect the transfer needs of the residents. Any concerns will be reported to the QA Committee for further action.5. Correction date: 9/24/2011	09/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	history of cerebral vascular accident, hypertension, depression and Diabetes Mellitus Type II. A quarterly Minimum Data Set (MDS) Assessment, dated 06/09/11, indicated Resident #19 was a two or more person physical assist when transferred from bed to wheelchair. The MDS indicated, in reference to moving from a seated to standing position, Resident # 19, "...Not steady, only able to stabilize with human assistance...." The MDS indicated Resident #19 had upper and lower extremity impairment to one side. A physical therapy evaluation, dated 02/04/11, indicated, "...Reason for Referral: Acute decline in mobility, safety. No longer able to ambulate and requies [sic] assist of 2 for bed<>wc [bed to wheelchair, wheelchair to bed]...Transfer: Bed<>Wheelchair - The patient is able to safely transfer from bed<>wheelchair requiring maximum assistance x [times] 2 [6-99% assist with 2 people]...." A progress note for Resident #19, dated 08/10/11 at 17:12 (5:12 p.m.), titled, "Fall," indicated, "...CNA was transferring resident from a sitting			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	position on the side of the bed to her w/c [wheelchair]. Using gait belt assist, resident stood and lost balance and CNA let resident to the floor onto knees...." A care plan, dated 06/27/11, titled, "Falls," indicated, "Potential for falls related to...CVA [cerebral vascular accident] with (l) [left] side hemiparesis and decrease mobility...Resident will remain free from falls...Assist with all transfers...." A care plan, dated 08/19/11, indicated Resident #19 needed physical therapy related to impaired transfer skills. During an interview on 08/25/11 at 8:25 a.m., regarding getting resident from the bed to the wheelchair, CNA #1 indicated Resident #19 was a one person physical transfer. CNA #1 indicated Resident #19 can pivot. During an interview with the Director of Nursing (DoN) on 08/25/11 at 10:05 a.m., a care plan specific to Resident #19's transfers was requested. During an interview on 08/25/11 at 11:30 a.m., the DoN indicated CNA's have transfer instructions on daily assignment sheets. The DoN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated that prior to 08/10/11, Resident #19 was a stand, pivot and transfer, which was a one person physical transfer according to the standards. No further care plans were provided at this time. The record lacked documentation of Resident #19's plan of care for two person physical transfers from the bed to wheelchair, or wheelchair to bed. 3.1-35(a) 3.1-35(b)(1)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to use a two person	F0323	1. The Certified Nursing Assistant assignment sheets were reviewed and updated.2. All	09/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	physical assist for transferring from the bed to the wheelchair for 1 of 2 residents reviewed for accidents/hazards in a stage two sample of 33. (Resident #19) Findings include: The record for Resident #19 was reviewed on 08/24/11 at 2:44 p.m. Diagnoses included, but were not limited to lower gastrointestinal bleed, history of cerebral vascular accident, hypertension, depression and Diabetes Mellitus Type II. A quarterly Minimum Data Set (MDS) Assessment, dated 06/09/11, indicated Resident #19 was a two or more person physical assist when transferred from bed to wheelchair. The MDS indicated, in reference to moving from a seated to standing position, Resident # 19, "...Not steady, only able to stabilize with human assistance...." The MDS indicated Resident #19 had upper and lower extremity impairment to one side. A physical therapy evaluation, dated 02/04/11, indicated, "...Reason for		residents have the potential to be affected.3. The Certified Nursing Assistants were in-serviced concerning checking their assignment sheets to ensure the appropriate transfer method is used during transfer. All residents transfer needs will be reviewed to ensure the appropriate transfer is being used. The Certified Nursing Assistant assignment sheets will be updated as necessary.4. DON or designee will audit 5 resident's transfer needs per week times two months to ensure the appropriate transfer methods are in place and are correct on the Certified Nursing Assistant assignment sheets. The results of the audit will be presented at the monthly QA Committee meeting and any recommendations made will be followed.5. Correction Date: 9/24/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Referral: Acute decline in mobility, safety. No longer able to ambulate and requies [sic]assist of 2 for bed<>wc [bed to wheelchair, wheelchair to bed]...Transfer: Bed<>Wheelchair - The patient is able to safely transfer from bed<>wheelchair requiring maximum assistance x [times] 2 (76-99% assist with 2 people)...." A care plan, dated 06/27/11, titled, "Falls," indicated, "Potential for falls related to...CVA [cerebral vascular accident] with (l) [left] side hemiparesis and decrease mobility...Resident will remain free from falls...Assist with all transfers...." A progress note for Resident #19, dated 08/10/11 at 17:12 (5:12 p.m.), titled, "Fall," indicated, "...CNA was transferring resident from a sitting position on the side of the bed to her w/c [wheelchair]. Using gait belt assist, resident stood and lost balance and CNA let resident to the floor onto knees...." A Fall Investigation Worksheet indicated Resident #19 fell on 08/10/11 at 4:50 p.m. The worksheet indicated Resident #19 had a sore right knee and twisted right ankle.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A progress note, dated 08/10/11 at 23:27 (11:27 p.m.), titled "Physician's Order Note," indicated, "Radiology was here to get X-Rays...Medicated resident for pain with 2 tabs of Acetaminophen...." During an interview on 08/25/11 at 8:25 a.m., regarding getting Resident #19 from the bed to the wheelchair, CNA #1 indicated Resident #19 was a one person physical transfer. CNA #1 indicated Resident #19 can pivot. During an interview on 08/25/11 at 11:30 a.m., the Director of Nursing indicated CNA's have transfer instructions on daily assignment sheets. The DoN indicated that prior to 08/10/11, Resident #19 was a stand, pivot and transfer, which was a one person physical transfer according to the standards. 3.1-45(a)(2)			